

not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.

(2) The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.

(3) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 62 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.

(4) If home health aide services are provided by an individual who is not employed directly by the HHA (or hospice), the services of the home health aide must be provided under arrangements, as defined in section 1861(w)(1) of the Act. If the HHA (or hospice) chooses to provide home health aide services under arrangements with another organization, the HHA's (or hospice's) responsibilities include, but are not limited to—

(i) Ensuring the overall quality of the care provided by the aide;

(ii) Supervision of the aide's services as described in paragraphs (d)(1) and (d)(2) of this section; and

(iii) Ensuring that home health aides providing services under arrangements have met the training requirements of paragraphs (a) and (b) of this section.

(e) *Personal care attendant: Evaluation requirements—(1) Applicability.* This paragraph applies to individuals who are employed by HHAs exclusively to furnish personal care attendant services under a Medicaid personal care benefit.

(2) *Rule.* An individual may furnish personal care services, as defined in § 440.170 of this chapter, on behalf of an HHA after the individual has been found competent by the State to furnish those services for which a competency evaluation is required by paragraph (b) of this section and which the

individual is required to perform. The individual need not be determined competent in those services listed in paragraph (a) of this section that the individual is not required to furnish.

[54 FR 33367, August 14, 1989, as amended at 56 FR 32974, July 18, 1991; 56 FR 51334, Oct. 11, 1991; 59 FR 65498, Dec. 20, 1994; 60 FR 39123, Aug. 1, 1995]

**§ 484.38 Condition of participation: Qualifying to furnish outpatient physical therapy or speech pathology services.**

An HHA that wishes to furnish outpatient physical therapy or speech pathology services must meet all the pertinent conditions of this part and also meet the additional health and safety requirements set forth in §§ 485.711, 485.713, 485.715, 485.719, 485.723, and 485.727 of this chapter to implement section 1861(p) of the Act.

[54 FR 33367, Aug. 14, 1989, as amended at 60 FR 2329, Jan. 9, 1995; 60 FR 11632, Mar. 2, 1995]

**§ 484.48 Condition of participation: Clinical records.**

A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.

(a) *Standards: Retention of records.* Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations. If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.

(b) *Standards: Protection of records.* Clinical record information is safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and the conditions for release of information. Patient's written consent is required for release of information not authorized by law.

[54 FR 33367, Aug. 14, 1989, as amended at 60 FR 65498, Dec. 20, 1994]

**§ 484.52 Condition of participation: Evaluation of the agency's program.**

The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

(a) *Standard: Policy and administrative review.* As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.

(b) *Standard: Clinical record review.* At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. There is a continuing review of clinical records for each 62-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.

**§ 484.55 Condition of participation: Comprehensive assessment of patients.**

Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary.

(a) *Standard: Initial assessment visit.* (1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.

(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

(b) *Standard: Completion of the comprehensive assessment.* (1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.